STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
500 JAMES ROBERTSON PARKWAY
NASHVILLE, TN 37243-1131

March 17, 2009

Western & Southern Life Ins Company
400 Broadway
Cincinnati, OH 45202
NAIC # 70483

CERTIFIED MAIL
RETURN RECEIPT REQUESTED
7008 1830 0000 6982 2781
Cashier # 2189

FILED Mar 23, 2009 @ 2:57 p.m.
Sarah Housewright, Clerk & Master
By: Karen Vaccaro DC

Re: Granville D. Marshall V. Western & Southern Life Ins Company

Docket # K0036290 (C)

To Whom It May Concern:

We are enclosing herewith a document that has been served on this department on your behalf in connection with the above-styled matter.

I hereby make oath that the attached Breach Of Contract Complaint was served on me on March 16, 2009 by Granville D. Marshall pursuant to Tenn. Code Ann. § 56-2-504 or § 56-2-506. A copy of this document is being sent to the Chancery Court of Sullivan County, TN.

Brenda C. Meade
Designated Agent
Service of Process

Enclosures

cc: Chancery Court Clerk
Sullivan County
P O Box 327
Blountville, Tn 37617

EXHIBIT A

(COW 1

STATE OF TENNESSEE
SUMMONS

Granville D Marshall

VS.

Western and Southern Life Insurance Company
Serve through Commissioner of Insurance
Policy # 9918767

CHANCERY COURT
AT
(KINGSPORT) (~~BLOUNTVILLE~~) (~~BRISTOL~~)
TENNESSE

CIVIL ACTION NO. K0036297
(C)

TO THE ABOVE NAMED DEFENDANT(S):

You are hereby summoned and required to serve upon R. Wayne Culbertson, Plaintiff's attorney, whose address is 119 W. Market St. Kingsport TN 37660 an answer to the complaint which is herewith served upon you within thirty (30) days after service of this summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint.

Filed, tested, and issued this 6th day of March 2009 @ 2:26 a.m./p.m.

SARAH HOUSEWRIGHT
Clerk & Master

By: Janet Pearson
Deputy Clerk &Master

Received this _____ day of _____, _____.

_____ Deputy Sheriff

RETURN

I, certify and return that I:

Served this summons together with the complaint as follows:

_____

_____

Failed to serve this summons within ninety (90) days after its issuance because: _____

_____

_____

Date _____

_____
Deputy Sheriff

ACCEPTANCE OF SERVICE

I,_____, hereby accept service of process in this case as fully and in all respects, as though I had been personally served by a Deputy Sheriff of Sullivan County, and I acknowledge that I received a copy of the summons and complaint in this case.

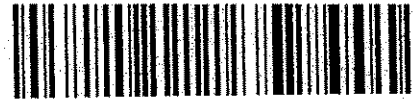
This the _____ day of _____, _____.

_____
Witness

_____
Defendant

NOTICE

TO THE DEFENDANT(S):
Tennessee law provides a four thousand dollar ($4,000) personal property exemption from execution or seizure to satisfy a judgment. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by you thereafter as necessary; however, *unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list.* Certain items are automatically exempt by law and do not need to be listed; these include items of necessary wearing apparel (clothing) for yourself and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible, and school books. Should any of these items be seized you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer.



7008 1830 0000 6982 2781

7008 1830 0000 6982 2781 3/17/09
WESTERN & SOUTHERN LIFE INS COMPANY
400 BROADWAY
CINCINNATI, OH 45202

Def

STATE OF TENNESSEE

SUMMONS

Granville D Marshall

VS.

Western and Southern Life [illegible]
[illegible]
Serve through Commissioner of Insurance
[illegible] # 9918767

CHANCERY COURT
AT
(KINGSPORT) (BLOUNTVILLE) (BRISTOL)
TENNESSE

CIVIL ACTION NO. K0036290 (C)

TO THE ABOVE NAMED DEFENDANT(S):

You are hereby summoned and required to serve upon [illegible] Plaintiff's attorney, whose address is [illegible] St. Kingsport TN 37660 an answer to the complaint which is herewith served upon you within thirty (30) days after service of this summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint.

Filed, tested, and issued this 6th day of March 2009 @ 2:26 a.m./p.m.

SARAH HOUSEWRIGHT
Clerk & Master

By: [signature]
Deputy Clerk &Master

Received this _____ day of ________________, _______.

________________________________ Deputy Sheriff

RETURN

I, certify and return that I:

Served this summons together with the complaint as follows: ________________

03/13/09 2:13 PM 00488749 $15.00

Failed to serve this summons within ninety (90) days after its issuance because: ________________

Date ________________ ________________
Deputy Sheriff

I HEREBY CERTIFY THIS IS A TRUE AND CORRECT COPY OF THE ORIGINAL FILED IN THIS OFFICE

ACCEPTANCE OF SERVICE

I, ______________________________, hereby accept service of process in this case as fully and in all respects, as though I had been personally served by a Deputy Sheriff of Sullivan County, and I acknowledge that I received a copy of the summons and complaint in this case.

This the _______ day of ________________, __________.

________________ ________________
Witness *Defendant*

NOTICE

TO THE DEFENDANT(S):
Tennessee law provides a four thousand dollar ($4,000) personal property exemption from execution or seizure to satisfy a judgment. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by you thereafter as necessary; however, *unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list.* Certain items are automatically exempt by law and do not need to be listed; these include items of necessary wearing apparel (clothing) for yourself and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible, and school books. Should any of these items be seized you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer.

IN THE CHANCERY COURT FOR SULLIVAN COUNTY
AT KINGSPORT, TENNESSEE

GRANVILLE D. MARSHALL,	)	
	)	
Plaintiff,	)	
	)	
Vs.	)	**Civil Action No.:** K0036290
	)	
WESTERN AND SOUTHERN LIFE INSURANCE COMPANY,	)	
	)	
	)	
Defendant.	)	

FILED 3-6, 2009 @ 2:20 a.m./p.m.
Sarah Housewright, Clerk & Master
By: Janet Pearce

COMPLAINT

1. The Plaintiff is a citizen and resident of Sullivan County, Tennessee, and the Defendant is a foreign corporation doing business in the State of Tennessee, with its home office located at 400 Broadway, Cincinnati, Ohio.

2. The Defendant, on/or about November 14, 1991, issued to the Plaintiff, Granville D. Marshall, a policy of insurance the same having Policy No. 991876, wherein it promised to pay policy benefits to the insured for the treatment of cancer, subject to the terms and conditions of the policy. The Plaintiff attaches hereto a copy of the policy as Exhibit #1 to this Complaint.

3. The Plaintiff, in the year of 2001 and subsequent thereto, became ill; he was diagnosed with cancer, and he has undergone numerous treatments including but not limited to radiation, chemotherapy and other drugs and as a result thereof, has accumulated numerous bills for treatment.

4. The Plaintiff, pursuant to the terms of the policy, submitted to the Defendant's

insurance company, a copy of the medical bills, along with medical statements and requested the same be paid pursuant to the provisions of the policy; however, the Defendant has failed and refused to do so.

5. The Plaintiff contends he has complied in all respects with the policy, that he has paid all premiums, that he has given the insurance company proper notice, pursuant to the terms and conditions of the policy, and further, on November 17, 2008, he caused a letter to be written to Defendant requesting it honor the conditions of the policy. Plaintiff attaches hereto a copy of the correspondence as Exhibit #2 to this Complaint.

6. It is the Plaintiff's position that the Defendant is in breach of contract, that Defendant has failed to abide by the terms and conditions of the policy and that based on its failure to comply with the conditions of the policy and pay pursuant to same is guilty of bad faith and the Plaintiff is seeking damages pursuant the bad faith statute of the state of Tennessee, along with all other payments which are due pursuant to the policy of insurance.

WHEREFORE, THE PLAINTIFF DEMANDS:

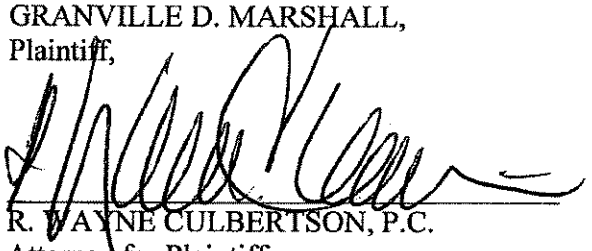
1. That process issue.

2. That Defendant be ordered to comply with the provisions of the policy and pay all medical bills which he has incurred as a result of treatment and for his condition covered by the policy, including but not limited to hospitalization, drugs, and chemotherapy treatment, plus pre-judgment interest.

3. That the Defendant be ordered to pay damages pursuant to T.C.A. 56-7-105.

4. For such other and further relief.

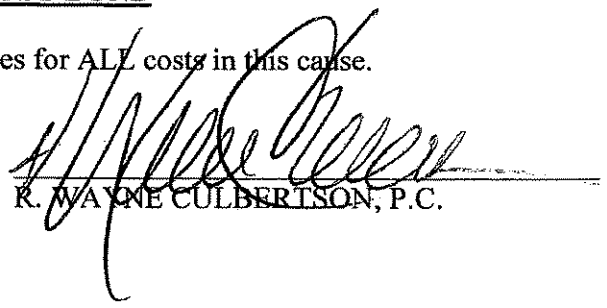
Respectfully Submitted,
GRANVILLE D. MARSHALL,
Plaintiff,

By: 

R. WAYNE CULBERTSON, P.C.
Attorney for Plaintiff
119 West Market Street
Kingsport, TN 37660
(423) 247-6161

COST BOND

We acknowledge ourselves as sureties for ALL costs in this cause.



R. WAYNE CULBERTSON, P.C.

THE WESTERN AND SOUTHERN LIFE INSURANCE COMPANY

INSURED	GRANVILLE D. MARSHALL	53 AGE
POLICY NUMBER	9918767	11-14-91 POLICY DATE
		F31-2-22 DISTRICT

A MUTUAL COMPANY

CINCINNATI, OHIO

We, The Western and Southern Life Insurance Company, will pay the policy benefits to you, the Insured, when you send us proof that you have incurred Covered Expenses on behalf of a Covered Person for the treatment of cancer, subject to the terms of this policy.

Payment of the first premium and completion and approval of the application put the policy in force starting with the Policy Date. A copy of the application is attached.

RENEWAL

The policy will continue in force for the term for which the first premium is paid. Another premium will be due on the day after the end of each term for which a premium has been paid. You may select any term for which a premium is shown on the Data Page and which would not renew the policy beyond the next policy anniversary.

We will renew the policy each time you pay a premium on or before its due date or within the 31-day period (grace period) that follows if all prior premiums have been paid when due. The policy will continue in force during the grace period. If a premium is not paid the policy will terminate at the end of the grace period. The policy will terminate upon the later of the death of yourself or of your spouse if a Covered Person.

PREMIUM RATE CHANGE

Premium rates cannot be changed unless the rates are changed for all policies of this premium class and plan in your state. Any such change will become effective only on a policy anniversary.

IMPORTANT NOTICE AND OPTION

Please read the copy of the application. If anything is not correct, you should tell us since your policy may not be a valid contract, thus not be in force when you have a claim.

You should also read your policy. If you are not satisfied, you may return it to us within 10 days after you receive it. If you return it, the policy will be considered never to have been in force. We will refund your money.

Ex # 1

Cancer Policy—Individual and Spouse

THIS IS A PARTICIPATING POLICY AND IS GUARANTEED RENEWABLE AS PROVIDED ON THE FACE PAGE SUBJECT TO CHANGE OF PREMIUM RATES BY CLASS. THE POLICY PROVIDES FOR PAYMENT IN THE AMOUNT FOR THE PERIOD AND TO THE EXTENT HEREIN PROVIDED FOR LOSS DUE TO SURGERY, HOSPITAL CONFINEMENT AND OTHER MEDICAL EXPENSES RESULTING FROM CANCER.

8907-4363

DEFINITION OF CANCER

Cancer is a sickness that is diagnosed and confirmed in writing by a qualified pathologist as carcinoma, sarcoma, leukemia, lymphoma, Hodgkin's disease or any other form of malignant tumor or growth. The pathologist's diagnosis and confirmation must be based on examination of tissue, blood or secretion.

OTHER DEFINITIONS

A "hospital" is an institution licensed to provide and operate facilities for medical, diagnostic and surgical treatment of sick and injured persons on an inpatient basis for which a charge is made, operated under the supervision of a staff of duly licensed physicians, and providing 24 hour nursing service under the supervision of registered graduate professional nurses. The term hospital does not include any facility contracted for or operated by the United States for members or former members of the armed forces or any facility or part of a facility which is used primarily for a clinic, continued or extended care facility, skilled nursing facility, convalescent hospital, facility for drug addicts or alcoholics, rest home, nursing home or home for the aged.

An "outpatient surgical center" is an institution which would meet the definition of "hospital" except that it operates on an outpatient basis only.

"Hospital confinement" is necessary confinement for a period of at least 12 hours as an inpatient in a hospital because of cancer. Such confinement must have been upon the recommendation and under the general supervision of a physician.

A "physician" is any person, other than yourself or your spouse, who is licensed and legally qualified to diagnose and treat cancer.

"We", "our" and "us" refer to The Western and Southern Life Insurance Company and "you", "your" and "yourself" refer to the Insured.

COVERED PERSONS; INSURED

Covered Persons—You, as the Insured, are a Covered Person. Your spouse named in the application is a Covered Person.

Premium—The premium for the policy will be appropriately reduced upon your death or the death of your spouse if a Covered Person.

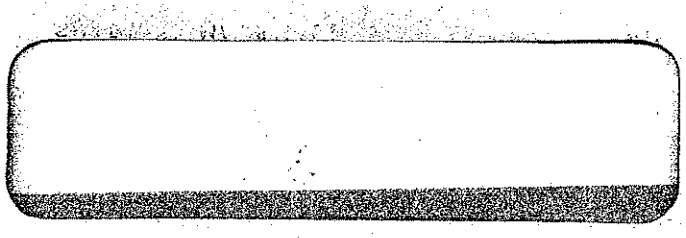
Insured—You are the Insured as long as the policy remains in force during your lifetime. If your spouse survives you and is then a Covered Person and if the policy is then in force, your spouse will then become the new Insured. References to you in the policy will then refer to your spouse.

POLICY LIMITATIONS

Policy benefits are payable only for cancer that is first manifested and for which treatment is first received at least 90 days after the person involved became covered under the policy and while the policy is in force. The policy does not cover any other disease or sickness unless a rider is included in the policy for that purpose. It does not cover injuries.

Policy benefits will not be paid for Covered Expenses incurred at a time when the person involved was not covered under the policy.

No benefits will be paid for confinement, for medical or surgical treatment, or for services performed or supplies furnished, in a hospital owned or operated by any state or local government or any political subdivision or agency of either except to the extent of the amount actually charged therefor.



INSURED GRANVILLE D. MARSHALL 53 AGE

11-14-91 POLICY DATE

INSURED	GRANVILLE D. MARSHALL	53	AGE
POLICY NUMBER	9918767	11-14-91	POLICY DATE
		F31-2-22	DISTRICT
SPOUSE	SHIRLEY MARSHALL	48	AGE

SCHEDULE OF PREMIUMS

	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
INSURED CANCER	$119.95	$ 62.37	$ 31.79	$ 11.39
SPOUSE CANCER	60.00	31.20	15.90	5.70
TOTAL PREMIUM AT ISSUE	$179.95	$ 93.57	$ 47.69	$ 17.09

INITIAL PRE-AUTHORIZED CHECK PREMIUM - $ 15.60 MONTHLY.

BENEFITS

POLICY BENEFITS FOR THE TREATMENT OF CANCER OF COVERED PERSONS, AS DESCRIBED IN THE POLICY.

8907-436

1200

APPLICATION FOR CANCER POLICY

THE WESTERN AND SOUTHERN LIFE INSURANCE COMPANY | A MUTUAL COMPANY | CINCINNATI, OHIO 45202

DISTRICT OR DETACHED OFFICE NAME

Payroll No.

DIST | DHO | AGT. NO. | AGENT'S NAME

F31 | 2 | 22 | A Calhoun | H8375

For Home Office Use Only

1. Proposed Insured: GRANVILLE D. MARSHALL

2. Address: 230 FEDDERSON ST

City: KINGSPORT | State: TN | Zip Code: 37660

3. ☒ Male ☐ Female | 4. Date of Birth: Month 3 | Day 12 | Year 38 | 5. Age last birthday: 57

6. Type of coverage applied for: Individual coverage ☒ | Spouse coverage ☒ | Children coverage ☐

CancerCare Plus: ☐ ☐ ☐

7. Supplementary benefits desired: ☐ Return of Premiums Rider ☐ Dread Disease Rider

8. BENEFICIARY DESIGNATION (COMPLETE ONLY IF RETURN OF PREMIUMS RIDER IS DESIRED)

A. Class I Beneficiary: | Relationship to Proposed Insured: | Age:

B. Class II Beneficiary: | Relationship to Proposed Insured: | Age:

9. APPLICANT'S SPOUSE (COMPLETE ONLY FOR SPOUSE COVERAGE)

A. Name	B. Date of birth Mo.	Day	Yr.	C. Age last birthday
SHIRLEY MARSHALL	7	4	43	48

10. DEPENDENT CHILDREN (COMPLETE ONLY FOR CHILDREN COVERAGE)

11. Amount paid with application: $ 15.60

12. Mode of premium payment: ☐ A ☐ S ☐ Q ☐ MO ☒ PAC ☐ MAO

13. Does any person listed above now have or has any person listed above ever had, or ever been treated for, cancer including carcinoma, sarcoma, leukemia, lymph Hodgkin's disease or any other form of malignant tumor or growth? ☐ YES ☒ NO If YES, please list the name(s) of those person(s), since they will be excluded coverage under this policy including supplementary benefits.

ANSWER 14 and 15 ONLY IF DREAD DISEASE RIDER IS DESIRED

14. Does any person listed above now have or has any person listed above ever had, or ever been treated for, Cystic Fibrosis, Multiple Sclerosis, Muscular Dyst Osteomyelitis, Sickle cell Anemia, or Tuberculosis? ☐ YES ☐ NO

15. Does any person listed above now have or has any person listed above being treated for, Diphtheria, Encephalitis, Meningitis, Poliomyelitis, Rabies, Rocky Mo Spotted Fever, Scarlet Fever, Smallpox, Tetanus, Tularemia, or Typhoid Fever? ☐ YES ☐ NO

If YES to 14 or 15, list the name(s) of those person(s) since they will be excluded from coverage under the Dread Disease Rider.

I hereby declare that to the best of my knowledge and belief the statements and answers to the above questions are complete and true. It is agreed: (1) If this appli approved by the Company at its Home Office for a policy as applied for and if the amount paid at the time of signing this application is sufficient to pay the full term pre such policy the insurance shall take effect as of the policy date and (2) Unless the insurance takes effect as provided in (1), no insurance shall take effect unless and unt (3) Issued by the Company and accepted by the applicant and the full term premium is paid while all conditions remain as stated in this application and (3) No agent or person except your Chairman, President or Secretary has power to make or modify any contract of insurance or to bind the Company by making any promise or repre

Signature of applicant: Granville D. Marshall | Signature of licensed agent: A. Calhoun

Date: 11-4-91

Covered Expenses include only the specified expenses listed below which are provided, ordered or prescribed by a physician as necessary in the treatment of cancer. Policy benefits are Covered Expenses limited to the lesser of the usual and customary charges in the geographic area involved and the stated maximums. Covered Expenses will be considered as incurred on the date the service was rendered or the supplies were furnished. The overall maximum we will pay is stated below.

Hospital Room and Board and Other Expenses—The charges made during confinement by a hospital for room and board, for the use of operating rooms and for anesthetics, surgical dressings, X-ray examinations, laboratory tests, drugs, medicines, oxygen and other necessary medical services and supplies furnished by the hospital, but not including charges for the services of physicians and nurses or charges for radiation therapy or blood transfusions (since these four items are listed separately) and not to exceed in the aggregate $80 for each day of hospital confinement .

Outpatient Surgical Expenses—The charges, which are not otherwise covered, made by an outpatient surgical center, or by a hospital, in connection with outpatient surgery, for the use of operating rooms and for anesthetics, surgical dressings, X-ray examinations, laboratory tests, drugs, medicines, oxygen and other necessary medical services and supplies furnished by such facility, but not including charges for the services of physicians and nurses or charges for radiation therapy or blood transfusions (since these four items are listed separately) and not to exceed in the aggregate $80 per surgical procedure. All surgical procedures performed at one operating session shall be considered one procedure.

Radiation Therapy—The charges made by a hospital or physician for radiation therapy provided either on an inpatient or outpatient basis.

Attending Physician—The charges made by a physician for professional visits, exclusive of surgery, postoperative care and radiation therapy, but not to exceed for any Covered Person $25 per day for visits each day.

Surgery—The charges made by a physician for surgery and postoperative care other than radiation therapy, but not to exceed the amount shown in the Surgical Schedule. The amount payable for any surgical procedure not listed will be determined by us consistent with the limits in the schedule for comparable operations and will not exceed the largest amount shown in the Surgical Schedule. Surgical procedures performed through the same incision or in the same body opening will be considered one procedure and the procedure with the highest maximum benefit will apply.

Anesthetist—The charges made by a qualified anesthetist, but not to exceed $150 for each operating session.

Nursing Services—The charges for care and attendance by a registered graduate nurse(s) or licensed practical nurse(s), but not to exceed in the aggregate for any Covered Person $60 a day. The nurse(s) must serve only the Covered Person involved while on duty and must not be a member(s) of your or your spouse's family.

Blood Transfusions—The charges for blood transfusions, including medical expenses incurred for blood donors, except that payment will not be made for blood which is donated or replaced.

Drugs and Medicines—The charges for all prescription drugs and medicines, except those administered while confined in a hospital or in connection with outpatient surgery.

Prostheses—The charges for prostheses required as a result of surgery, but not to exceed for any Covered Person a total of $2,000.

Transportation—The charges for transportation of any Covered Person with cancer and one attendant by commercial aircraft, train, bus or professional ambulance to and from any hospital within the continental United States, but not to exceed six such trips to and from a hospital in any period of 12 consecutive months.

Overall Maximum—The maximum amount of Covered Expenses which we will pay under this policy for any Covered Person is $300,000.

SURGICAL SCHEDULE

The benefit may not exceed the lowest of the actual charge, the usual and customary charge in the geographic area involved, and the stated Maximum Amount.

	Maximum Amount
ABDOMEN	
Cutting through abdominal wall for removal of organs (unless otherwise specified below)	$300.00
Removal of the stomach	575.00
Partial resection of the stomach	425.00
Resection of colon	450.00
Combined abdominal-perineal resection or cancer of the rectum or sigmoid	575.00
Colostomy or ileostomy	275.00
Resection of esophagus	700.00
Gastrostomy	300.00
Splenectomy	400.00
EYE	
Removal of eye	250.00
AMPUTATIONS	
Thigh	350.00
Arm, forearm, entire hand, leg, or entire foot	350.00
Fingers or toes, each	125.00
BRAIN	
Exploratory craniotomy	300.00
Removal of cancer of brain	750.00
BREAST	
Radical mastectomy	425.00
Simple mastectomy	275.00
CHEST	
Exploratory thoracotomy	300.00
Removal of all or major segment of lung	600.00

	Maximum Amount
GENITO-URINARY	
Complete excision or removal of the vulva or vagina with regional lymph nodes	$500.00
Dilatation and curettage and/or conization of the cervix	125.00
Cancer of penis—complete excision and removal of regional lymph nodes	575.00
Removal of testicle(s)	300.00
Removal of kidney	550.00
Removal of prostate, complete procedure	550.00
Removal of uterus, tubes and ovaries	450.00
Complete cystectomy with ureteral transplant	700.00
Partial excision of the bladder	425.00
SKIN	
Cutting operation for removal from:	
Lip	150.00
Ear	125.00
Nose	150.00
Mouth, tongue, tonsil or mucous membrane of the mouth	250.00
Other parts of body	125.00
SPINAL	
Removal of portion of vertebra or vertebrae	700.00
THROAT	
Excision of larynx	575.00
Excision of larynx with neck dissection	750.00
Removal of thyroid	400.00

GENERAL PROVISIONS

Entire Contract; Changes—This policy with the application and any attached papers is the entire contract between you and us. No change in this policy will be effective until approved by one of our officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

Time Limit on Certain Defenses—(a) Misstatements in the Application: After two years from the Policy Date only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred after the two year period.

(b) Pre-existing Conditions: No claim for loss incurred after two years from the Policy Date will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage.

Grace Period—This policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period the policy will stay in force.

Reinstatement—If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by us (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If we or our agent require an application, you will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless we have previously written you of our disapproval.

The reinstated policy will cover only loss that results from sickness that starts more than 10 days after the date of reinstatement. In all other respects your rights and ours will remain the same, subject to any provisions noted on or attached to the reinstated policy.

Notice of Claim—Written notice of claim must be given within 30 days after a covered loss starts or as soon as reasonably possible. The notice can be given to us at our Home Office in Cincinnati, Ohio or to our agent. Notice should include your name and your policy number.

Claim Forms—When we receive the notice of claim, we will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.

Proofs of Loss—Written proof must be given to us at our Home Office within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, we shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

Time of Payment of Claims—Benefits for any loss covered by this policy will be paid as soon as we receive proper written proof.

Payment of Claims—Benefits will be paid to you. Any benefits unpaid at your death will be paid to your estate.

If benefits are payable to your estate or if you cannot execute a valid release, we can pay benefits up to $1,000 to someone related to you by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

Physical Examinations—We at our expense have the right to have any Covered Person examined as often as reasonably necessary while a claim is pending on such person.

Legal Actions—No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after three years from the time written proof of loss is required to be given.

Misstatement of Age—If your age or the age of your spouse has been misstated, the benefits will be those the premium paid would have purchased at the correct ages.

If any age is misstated and if, according to the correct age, coverage provided by the policy would not have become effective, then our liability shall be limited to the refund, upon written notice, of all applicable premiums paid.

Other Insurance With Us—If any Covered Person is covered under more than one cancer policy with us at one time, only one policy chosen by you will be effective as to such person. We will refund all applicable premiums paid at any time for all policies in excess of one in force at that time.

Conformity with State Statutes—Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which you reside on that date is amended to conform to the minimum requirements of such laws.

Participation—This policy shall be entitled to dividends to the extent and upon the conditions determined by us.

Assignment—Any assignment of policy benefits shall not be binding upon us unless in writing nor until filed at our Home Office. We assume no responsibility for the validity or sufficiency of any assignment.

Notice of Annual Meeting—You are welcome to come to our Annual Meeting. It is held each year at our Home Office at 10:00 A.M. on the 2nd Tuesday in March. This policy does not entitle you to vote at the meeting.

THIS IS A LIMITED POLICY
READ IT CAREFULLY

IN WITNESS WHEREOF, The Western and Southern Life Insurance Company has caused this policy to be signed by its President and Secretary at Cincinnati, Ohio, but the same shall not be valid unless countersigned by a licensed resident agent of the Company.

Margaret A. Parks
Secretary

Chairman of the Board and
Chief Executive Officer

Countersigned at Kingsport, Tn By David Calhoun
Licensed Resident Agent

Cancer Policy—Individual and Spouse

THIS IS A PARTICIPATING POLICY AND IS GUARANTEED RENEWABLE AS PROVIDED ON THE FACE PAGE SUBJECT TO CHANGE OF PREMIUM RATES BY CLASS. THE POLICY PROVIDES FOR PAYMENT IN THE AMOUNT, FOR THE PERIOD AND TO THE EXTENT HEREIN PROVIDED, FOR LOSS DUE TO SURGERY, HOSPITAL CONFINEMENT AND OTHER MEDICAL EXPENSES RESULTING FROM CANCER.

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

(7) unallocated annuity contracts (which give rights to group contractholders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits that amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The Tennessee Life and Health Insurance Guaranty Association
P.O. Box 25th Floor
511 Union Street
Nashville, Tennessee 37219

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, Tennessee 37243

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policy-holders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by a nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy-holder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) any policy of reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contractholder;

FORM 1014-9004

R. WAYNE CULBERTSON, PC
Attorney at Law
119 W. Market Street
Kingsport, TN 37660
Telephone: (423) 247-6161
Facsimile: (423) 247-5072

November 17, 2008

Western - Southern Life Insurance Company
400 Broadway
Cincinnati, OH 45202

Re: Granville D. Marshall
Policy Number: 9918767
Policy Date: 11-14-1991

Dear Sir or Madam:

I represent Mr. Granville D. Marshall, the insured pursuant to the above captioned policy. Mr. Marshall has been diagnosed with cancer and as a result thereof has incurred numerous medical bills including a substantial bill for chemotherapy. In talking with Mr. Marshall, it is my understanding that he has submitted chemotherapy bills to agents of Western and Southern Life Insurance Company; however, payment of same has been denied. It is Mr. Marshall's position that the bills are covered, that he has complied in all respects with the policy and that he is requesting payment be made immediately.

Mr. Marshall, pursuant to T.C.A. § 56-7-105 is notifying you that there is additional liability upon insurers and bonding companies for bad faith and failure to pay promptly and that we will be asking for penalties pursuant to the statute in the event payments are not made immediately. I am attaching hereto a copy of the Statute for a fuller explanation thereof.

Thanking you for your consideration.

Yours very truly,
R. WAYNE CULBERTSON, P.C.

R. Wayne Culbertson

RWC/cb
enclosure

EX No 2

8213246

DIST. F31-2 22

REPT. 9245
DEPT. 0858

PAYMENT SUMMARY CANCER/DREAD DISEASE EXPENSE POLICY
03-30-94

GRANVILLE D MARSHALL
230 FEDDERSON STREET
KINGSPORT TN 37660

CLAIMANT-MARSHALL, GRANVILLE D.
POLICY NO. 0-0009918767
PLAN CODE-4363
DATE OF LOSS-10-07-1993
AMT PD TO DATE- $301.00

HOSPITAL ROOM AND BOARD	$0.00	NURSING SERVICES	$0.00
DAYS CONFINED	000	BLOOD TRANSFUSION	$0.00
OTHER HOSP EXP	$0.00	DRUGS AND MEDICINES	$0.00
OUTPATIENT		CHEMOTHERAPY	$0.00
SURGICAL EXPENSE	$80.00	PROSTHESES OR APPARATUS	$0.00
RADIATION THERAPY	$0.00	TRANSPORTATION	$0.00
ANESTHETIST	$0.00	FAMILY LODGING	$0.00
ATTENDING PHYSICIAN EXPENSE	$175.00	HOSPICE	$0.00
SURGICAL EXPENSE	$46.00	LONGTERM CARE	$0.00
		AMOUNT PAYABLE	$301.00

CHECKS MAILED TO:
DISTRICT-GRANVILLE D MARSHALL $301.00

830 3063

DIST. F31-2 22

REPT. 9245
DEPT. 0858

PAYMENT SUMMARY CANCER/DREAD DISEASE EXPENSE POLICY
06-01-94

GRANVILLE D MARSHALL
230 FEDDERSON ST
KINGSPORT TN 37660

CLAIMANT-MARSHALL, GRANVILLE
POLICY NO. 0-0009918767
PLAN CODE-4363
DATE OF LOSS-10-07-1993
AMT PD TO DATE- $2,781.00

HOSPITAL ROOM AND BOARD	$0.00	NURSING SERVICES	$0.00
DAYS CONFINED	000	BLOOD TRANSFUSION	$0.00
OTHER HOSP EXP	$0.00	DRUGS AND MEDICINES	$0.00
OUTPATIENT SURGICAL EXPENSE	$0.00	CHEMOTHERAPY	$0.00
RADIATION THERAPY	$2,480.00	PROSTHESES OR APPARATUS	$0.00
ANESTHETIST	$0.00	TRANSPORTATION	$0.00
ATTENDING PHYSICIAN EXPENSE	$0.00	FAMILY LODGING	$0.00
SURGICAL EXPENSE	$0.00	HOSPICE	$0.00
		LONGTERM CARE	$0.00
		AMOUNT PAYABLE	$2,480.00

CHECKS MAILED TO:
DISTRICT-GRANVILLE D MARSHALL $2,480.00

DIST. F31-2 22

REPT. 9245
DEPT. 0859

PAYMENT SUMMARY CANCER/DREAD DISEASE EXPENSE POLICY
07-02-94

GRANVILLE MARSHALL
230 FEDDERSON ST
KINGSPORT TN 37660

CLAIMANT-MARSHALL,GRANVILLE
POLICY NO. 0-0009918767
PLAN CODE-4363
DATE OF LOSS-10-07-1993
AMT PD TO DATE- $7,164.38

HOSPITAL ROOM AND BOARD	$0.00	NURSING SERVICES	$0.00
DAYS CONFINED	000	BLOOD TRANSFUSION	$0.00
OTHER HOSP EXP	$0.00	DRUGS AND MEDICINES	$13.38
OUTPATIENT SURGICAL EXPENSE	$0.00	CHEMOTHERAPY	$0.00
RADIATION THERAPY	$4,370.00	PROSTHESES OR APPARATUS	$0.00
ANESTHETIST	$0.00	TRANSPORTATION	$0.00
ATTENDING PHYSICIAN EXPENSE	$0.00	FAMILY LODGING	$0.00
SURGICAL EXPENSE	$0.00	HOSPICE	$0.00
		LONGTERM CARE	$0.00

AMOUNT PAYABLE $4,383.38

CHECKS MAILED TO:
DISTRICT-GRANVILLE MARSHALL $4,383.38

Western & Southern Life

A member of Western & Southern Financial Group®

January 21, 2009

GRANVILLE D MARSHALL
230 FEDDERSON ST
KINGSPORT TN 37660-1949

Subject: Cancer Policy #009918767

Dear Mr. Marshall:

I am writing to you today because when you give us your bill from Kingsport Hematology Oncology it does not give us enough information about the drugs that they are using for your chemotherapy. I talked to the biller, Debbie, and she said for you to ask for a bill that has the following information:

- ☒ Name of prescribed drug
- ☒ Dosage of drug
- ☒ Units administered
- ☒ Cost of Drug

The above information is used to calculate the benefit that you receive, so it is very important that we have this information. Please give a copy of this letter to your doctor's office next time you go in for chemotherapy.

To prevent possible delays in the processing of your claim, please note the following:

- Typically, the explanation of benefits and the statement of accounts forms from other insurance carriers do not provide all of the necessary information we need to process your claim. Make sure that you are providing all of the billing information indicated above.
- Please submit either HCFA-1500/CMS 1500 (physician billing) or UB-92/UB04 (hospital billing) form. These medical forms are the standard industry forms and should be available from your provider(s).
- We can not accept any handwritten information.

If you have any questions, please call 1-800-926-1315.

Sincerely,

Ms. Pat Van Derzee
Claims Approver
Claims Administration Department
The Western and Southern Life Insurance Company

DC0285-0809

Western-Southern Life
400 BROADWAY · CINCINNATI, OHIO · 45202

EXPLANATION OF CANCER CLAIM

POLICY NO	CLAIM ID NO	CLAIMANT	DATE	PAGE
009918767	033280036-00	GRANVILLE D MARSHALL	11/24/03	01 OF 01

SEND TO:

GRANVILLE D MARSHALL
230 FEDDERSON ST
KINGSPORT TN 37660-1949

BENEFITS PAID TO DATE:
$ 274.00

FIRST SERVICE DATE:
08-28-03

PLAN CODE:
4363

PROVIDER/DRUG NAME	SERV TYPE	DATES OF SERVICE FROM	DATES OF SERVICE TO	TOTAL CHARGES	INELIGIBLE CHARGES	* MSG	BENEFITS PAYABLE
00 HIGHLANDS PATH CO	OSC	091103	091103	200.00	120.00	XX	80.00
PAGE TOTALS				200.00	120.00		80.00
CLAIM TOTALS				200.00	120.00		80.00

*MESSAGES

XX YOU HAVE REACHED THE MAXIMUM ALLOWED UNDER OUTPATIENT SURGICAL EXPENSE BENEFIT, FOR THIS SERVICE DATE.
.. A CHECK FOR $ 80.00 WAS ISSUED TO GRANVILLE D MARSHALL

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

OSC OUTPATIENT SURGERY CHARGE

FORM G-27-C-9410 RETAIN THIS FORM FOR YOUR RECORDS CA009

Western-Southern Life
400 BROADWAY · CINCINNATI, OHIO · 45202

EXPLANATION OF CANCER CLAIM

POLICY NO	CLAIM ID NO	CLAIMANT	DATE	PAGE
009918767	082240045-00	GRANVILLE D MARSHALL	08/11/08	01 OF 01

SEND TO:

GRANVILLE D MARSHALL
230 FEDDERSON ST
PO BOX 2295
KINGSPORT TN 37662-2295

BENEFITS PAID TO DATE:
$ 324.00

FIRST SERVICE DATE:
08-28-03

PLAN CODE:
4363

PROVIDER/DRUG NAME	SERV TYPE	DATES OF SERVICE FROM	DATES OF SERVICE TO	TOTAL CHARGES	INELIGIBLE CHARGES	* MSG	BENEFITS PAYABLE
00 BLUE RIDGE RADIOL	NCE	062708	062708	470.00	470.00	XO	.00
00 BLUE RIDGE RADIOL	NCE	063008	063008	175.00	175.00	XO	.00
00 BLUE RIDGE RADIOL	DOC	071508	071508	100.30	75.30	YX	25.00
00 HOLSTON VALLEY IM	NCE	062708	062708	5,247.00	5,247.00	XO	.00
01 GASTROENTEROLOGY	DOC	101907	101907	208.18	183.18	YX	25.00
			PAGE TOTALS	6,200.48	6,150.48		50.00
			CLAIM TOTALS	6,200.48	6,150.48		50.00

*MESSAGES

XO THE CHARGES FOR THIS SERVICE ARE NOT COVERED UNDER THE TERMS OF YOUR POLICY.
YX YOU HAVE REACHED THE MAXIMUM PER TREATMENT ALLOWANCE FOR THIS BENEFIT.
.. THIS POLICY DOES NOT PROVIDE A BENEFIT THAT PAYS FOR LAB WORK AND X-RAYS. PLEASE REVIEW BENEFITS LISTED IN THE POLICY.
.. A CHECK FOR $ 50.00 WAS ISSUED TO GRANVILLE D MARSHALL

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

NCE NON-COVERED EXPENSES
DOC PHYSICIAN VISIT

FORM G-27-C-9410 RETAIN THIS FORM FOR YOUR RECORDS CA004

Western-Southern Life
400 BROADWAY · CINCINNATI, OHIO · 45202

EXPLANATION OF CANCER CLAIM

POLICY NO	CLAIM ID NO	CLAIMANT	DATE	PAGE
009918767	082460012-00	GRANVILLE D MARSHALL	09/02/08	01 OF 01

SEND TO:

GRANVILLE D MARSHALL
230 FEDDERSON ST
KINGSPORT TN 37660-1949

BENEFITS PAID TO DATE:
$ 915.00

FIRST SERVICE DATE:
08-28-03

PLAN CODE:
4363

PROVIDER/DRUG NAME	SERV TYPE	DATES OF SERVICE FROM	DATES OF SERVICE TO	TOTAL CHARGES	INELIGIBLE CHARGES	* MSG	BENEFITS PAYABLE
00 GASTROENTEROLOGY	DOC	101907	101907	208.18	208.18	Q1	.00
01 GASTROENTEROLOGY	SUR	020808	020808	790.32	790.32	XD	.00
01 GASTROENTEROLOGY	SUR	020808	020808	664.50	664.50	XD	.00
01 GASTROENTEROLOGY	DOC	051608	051608	190.67	190.67	Q1	.00
01 GASTROENTEROLOGY	OSC	020808	020808	838.40	838.40	XD	.00
01 GASTROENTEROLOGY	NCE	020808	020808	838.40	838.40	XO	.00
01 GASTROENTEROLOGY	OSC	060408	060408	838.40	758.40	XX	80.00
02 WELLMONT HOLSTON	OSC	061108	061108	1,947.75	1,867.75	XX	80.00
02 HOLSTON VALLEY IM	NCE	061308	061308	2,027.00	2,027.00	XO	.00
02 HOLSTON VALLEY IM	NCE	062708	062708	5,247.00	5,247.00	Q1	.00
02 HOLSTON VALLEY IM	NCE	063008	063008	5,213.00	5,213.00	XO	.00
02 BLUE RIDGE RADIOL	NCE	063008	063008	175.00	175.00	Q1	.00
03 SURGICAL ASSOC OF	DOC	013108	013108	147.00	122.00	YX	25.00
03 SURGICAL ASSOC OF	DOC	071508	071508	182.00	182.00	YX	.00
03 SURGICAL ASSOC OF	SUR	080408	080408	2,500.00	2,431.00		69.00
03 SURGICAL ASSOC OF	SUR	080408	080408	3,340.00	3,133.00	Y1	207.00
03 SURGICAL ASSOC OF	OSC	080408	080408	3,440.00	3,360.00	XX	80.00
03 WELLMONT HOLSTON	OSC	080408	080408	12,100.92	12,100.92	XX	.00
			PAGE TOTALS	40,688.54	40,147.54		541.00
			CLAIM TOTALS	40,688.54	40,147.54		541.00

*MESSAGES

Q1 DUPLICATE SERVICE.
XD DIAGNOSIS FOR TREATMENT IS NOT CANCER, NO BENEFIT IS PAYABLE.
XO THE CHARGES FOR THIS SERVICE ARE NOT COVERED UNDER THE TERMS OF YOUR POLICY.
XX YOU HAVE REACHED THE MAXIMUM ALLOWED UNDER OUTPATIENT SURGICAL EXPENSE BENEFIT, FOR THIS SERVICE DATE.
.. THIS POLICY DOES NOT PROVIDE A BENEFIT THAT PAYS FOR LAB WORK AND X-RAYS. PLEASE REVIEW BENEFITS LISTED IN THE POLICY.
YX YOU HAVE REACHED THE MAXIMUM PER TREATMENT ALLOWANCE FOR THIS BENEFIT.
Y1 THE CHARGES EXCEED THE AMOUNT ALLOWED BY YOUR POLICY.
.. A CHECK FOR $ 541.00 WAS ISSUED TO GRANVILLE D MARSHALL

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

DOC PHYSICIAN VISIT
OSC OUTPATIENT SURGERY CHARGE
SUR SURGEON
NCE NON-COVERED EXPENSES

FORM G-27-C-9410

RETAIN THIS FORM FOR YOUR RECORDS

CA007

Western-Southern Life
400 BROADWAY · CINCINNATI, OHIO · 45202

EXPLANATION OF CANCER CLAIM

POLICY NO	CLAIM ID NO	CLAIMANT	DATE	PAGE
009918767	082800044-00	GRANVILLE D MARSHALL	10/06/08	01 OF 01

SEND TO:

GRANVILLE D MARSHALL
230 FEDDERSON ST
KINGSPORT TN 37660-1949

BENEFITS PAID TO DATE:
$ 6,488.44

FIRST SERVICE DATE:
08-28-03

PLAN CODE:
4363

PROVIDER/DRUG NAME	SERV TYPE	DATES OF SERVICE FROM	DATES OF SERVICE TO	TOTAL CHARGES	INELIGIBLE CHARGES	* MSG	BENEFITS PAYABLE
00 SURGICAL ASSOC OF	SUR	080408	080408	2,500.00	2,500.00	Q1	.00
00 SURGICAL ASSOC OF	SUR	080408	080408	840.00	840.00	Q1	.00
00 SURGICAL ASSOC OF	OSC	080408	080408	100.00	100.00	XX	.00
00 SURGICAL ASSOC OF	NCE	080608	080608	100.00	100.00	XO	.00
			PAGE TOTALS	3,540.00	3,540.00		.00
			CLAIM TOTALS	3,540.00	3,540.00		.00

* MESSAGES

Q1 DUPLICATE SERVICE.
XX YOU HAVE REACHED THE MAXIMUM ALLOWED UNDER OUTPATIENT SURGICAL EXPENSE BENEFIT, FOR THIS SERVICE DATE.
XO THE CHARGES FOR THIS SERVICE ARE NOT COVERED UNDER THE TERMS OF YOUR POLICY.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

SUR SURGEON
NCE NON-COVERED EXPENSES
OSC OUTPATIENT SURGERY CHARGE

FORM G-27-C-9410

RETAIN THIS FORM FOR YOUR RECORDS

Western-Southern Life
400 BROADWAY · CINCINNATI, OHIO · 45202

EXPLANATION OF CANCER CLAIM

POLICY NO	CLAIM ID NO	CLAIMANT	DATE	PAGE
009918767	083040052-00	GRANVILLE D MARSHALL	10/30/08	01 OF 01

SEND TO:

GRANVILLE D MARSHALL
230 FEDDERSON ST
KINGSPORT TN 37660-1949

BENEFITS PAID TO DATE:
$ 14,643.89

FIRST SERVICE DATE:
08-28-03

PLAN CODE:
4363

PROVIDER/DRUG NAME	SERV TYPE	DATES OF SERVICE FROM	DATES OF SERVICE TO	TOTAL CHARGES	INELIGIBLE CHARGES	* MSG	BENEFITS PAYABLE
00 SOUTHWEST VA REGI	DOC	090908	090908	152.00	127.00	YX	25.00
			PAGE TOTALS	152.00	127.00		25.00
			CLAIM TOTALS	152.00	127.00		25.00

*MESSAGES

YX YOU HAVE REACHED THE MAXIMUM PER TREATMENT ALLOWANCE FOR THIS BENEFIT.
.. A CHECK FOR $ 25.00 WAS ISSUED TO GRANVILLE D MARSHALL

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

DOC PHYSICIAN VISIT

FORM G-27-C-9410 RETAIN THIS FORM FOR YOUR RECORDS CA012

Western-Southern Life
400 BROADWAY · CINCINNATI, OHIO · 45202

EXPLANATION OF CANCER CLAIM

POLICY NO	CLAIM ID NO	CLAIMANT	DATE	PAGE
009918767	083470082-00	GRANVILLE D MARSHALL	12/16/08	01 OF 01

SEND TO:

GRANVILLE D MARSHALL
230 FEDDERSON ST
KINGSPORT TN 37660-1949

BENEFITS PAID TO DATE:
$ 14,743.89

FIRST SERVICE DATE:
08-28-03

PLAN CODE:
4363

PROVIDER/DRUG NAME	SERV TYPE	DATES OF SERVICE FROM	DATES OF SERVICE TO	TOTAL CHARGES	INELIGIBLE CHARGES	* MSG	BENEFITS PAYABLE
00 KINGSPORT HEMATOL	RXP	082008	082008	8,294.00	8,294.00	X17	.00
00 KINGSPORT HEMATOL	NCE	082008	082008	47.00	47.00	Q1	.00
00 KINGSPORT HEMATOL	NCE	082608	082608	62.00	62.00	Q1	.00
00 KINGSPORT HEMATOL	NCE	090208	090208	62.00	62.00	Q1	.00
00 KINGSPORT HEMATOL	RXP	091008	091008	8,294.00	8,294.00	X17	.00
00 KINGSPORT HEMATOL	NCE	091008	091008	47.00	47.00	Q1	.00
01 KINGSPORT HEMATOL	NCE	091608	091608	62.00	62.00	Q1	.00
01 KINGSPORT HEMATOL	NCE	092308	092308	62.00	62.00	XO	.00
01 KINGSPORT HEMATOL	NCE	081908	081908	20.00	20.00	XO	.00
01 KINGSPORT HEMATOL	NCE	090908	090908	20.00	20.00	XO	.00
01 KINGSPORT HEMATOL	NCE	100908	100908	62.00	62.00	XO	.00
01 KINGSPORT HEMATOL	NCE	101608	101608	62.00	62.00	XO	.00
02 KINGSPORT HEMATOL	DOC	093008	093008	152.00	127.00	YX	25.00
02 KINGSPORT HEMATOL	NCE	093008	093008	129.00	129.00	XO	.00
02 KINGSPORT HEMATOL	RXP	093008	093008	7.00	3.32	X17	3.68
02 KINGSPORT HEMATOL	DOC	102008	102008	100.00	75.00	YX	25.00
02 KINGSPORT HEMATOL	DOC	111908	111908	152.00	127.00	YX	25.00
			PAGE TOTALS	17,634.00	17,555.32		78.68
			CLAIM TOTALS	17,634.00	17,555.32		78.68

* MESSAGES

X17 EXPENSES IN EXCESS OF USUAL, CUSTOMARY AND REASONABLE CHARGES ARE INELIGIBLE.
Q1 DUPLICATE SERVICE.
XO THE CHARGES FOR THIS SERVICE ARE NOT COVERED UNDER THE TERMS OF YOUR POLICY.
YX YOU HAVE REACHED THE MAXIMUM PER TREATMENT ALLOWANCE FOR THIS BENEFIT.
.. A CHECK FOR $ 78.68 WAS ISSUED TO GRANVILLE D MARSHALL

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

RXP PRESCRIPTION DRUGS
DOC PHYSICIAN VISIT
NCE NON-COVERED EXPENSES

FORM G-27-C-9410 RETAIN THIS FORM FOR YOUR RECORDS CA003

Western-Southern Life
400 BROADWAY · CINCINNATI, OHIO · 45202

EXPLANATION OF CANCER CLAIM

0821

POLICY NO	CLAIM ID NO	CLAIMANT	DATE	PAGE
009918767	082960082-03	GRANVILLE D MARSHALL	01/23/09	01 OF 01

SEND TO:

GRANVILLE D MARSHALL
230 FEDDERSON ST
KINGSPORT TN 37660-1949

BENEFITS PAID TO DATE:
$ 24,277.51

FIRST SERVICE DATE:
08-28-03

PLAN CODE:
4363

PROVIDER/DRUG NAME	SERV TYPE	DATES OF SERVICE FROM	DATES OF SERVICE TO	TOTAL CHARGES	INELIGIBLE CHARGES	* MSG	BENEFITS PAYABLE
03 KINGSPORT HEMATOL	RXP	090908	090908	.00	-2.90	X17	2.90
PAGE TOTALS				.00	-2.90		2.90
CLAIM TOTALS				.00	-2.90		2.90

*MESSAGES

X17 EXPENSES IN EXCESS OF USUAL, CUSTOMARY AND REASONABLE CHARGES ARE INELIGIBLE.
.. CORRECTION AND ADDITIONAL PAYMENT ON PREVIOUSLY PROCESSED CLAIM.
.. A CHECK FOR $ 2.90 WAS ISSUED TO GRANVILLE D MARSHALL

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

RXP PRESCRIPTION DRUGS

Western-Southern Life
400 BROADWAY · CINCINNATI, OHIO · 45202

EXPLANATION OF CANCER CLAIM

0821

POLICY NO	CLAIM ID NO	CLAIMANT	DATE	PAGE
009918767	090260091-00	GRANVILLE D MARSHALL	01/26/09	01 OF 02

SEND TO:

GRANVILLE D MARSHALL
230 FEDDERSON ST
KINGSPORT TN 37660-1949

BENEFITS PAID TO DATE:
$ 31,683.86

FIRST SERVICE DATE:
08-28-03

PLAN CODE:
4363

PROVIDER/DRUG NAME	SERV TYPE	DATES OF SERVICE FROM	DATES OF SERVICE TO	TOTAL CHARGES	INELIGIBLE CHARGES	* MSG	BENEFITS PAYABLE
00 KINGSPORT HEMATOL	RXP	082008	082008	8,294.00	8,294.00	Q1	.00
00 KINGSPORT HEMATOL	NCE	082008	082008	62.00	62.00	XO	.00
00 KINGSPORT HEMATOL	NCE	082608	082608	62.00	62.00	Q1	.00
00 KINGSPORT HEMATOL	NCE	090208	090208	62.00	62.00	Q1	.00
00 KINGSPORT HEMATOL	RXP	091008	091008	8,294.00	8,294.00	Q1	.00
00 KINGSPORT HEMATOL	NCE	091008	091008	47.00	47.00	Q1	.00
01 KINGSPORT HEMATOL	NCE	091608	091608	62.00	62.00	Q1	.00
01 KINGSPORT HEMATOL	NCE	092308	092308	62.00	62.00	Q1	.00
01 KINGSPORT HEMATOL	NCE	081908	081908	20.00	20.00	Q1	.00
01 KINGSPORT HEMATOL	NCE	090908	090908	20.00	20.00	Q1	.00
01 KINGSPORT HEMATOL	NCE	100908	100908	62.00	62.00	Q1	.00
01 KINGSPORT HEMATOL	NCE	101608	101608	62.00	62.00	Q1	.00
02 KINGSPORT HEMATOL	DOC	062408	062408	405.00	405.00	Q1	.00
02 KINGSPORT HEMATOL	DOC	070208	070208	152.00	152.00	Q1	.00
02 KINGSPORT HEMATOL	DOC	081208	081208	152.00	152.00	Q1	.00
02 KINGSPORT HEMATOL	NCE	081908	081908	1,184.00	1,184.00	Q1	.00
02 KINGSPORT HEMATOL	CHM	081908	081908	11,889.00	11,889.00	Q1	.00
02 KINGSPORT HEMATOL	RXP	081908	081908	780.00	780.00	Q1	.00
03 KINGSPORT HEMATOL	DOC	090908	090908	152.00	152.00	Q1	.00
03 KINGSPORT HEMATOL	NCE	090908	090908	1,098.00	1,098.00	Q1	.00
03 KINGSPORT HEMATOL	CHM	090908	090908	13,056.00	13,056.00	Q1	.00
03 KINGSPORT HEMATOL	RXP	090908	090908	780.00	780.00	Q1	.00
03 KINGSPORT HEMATOL	DOC	093008	093008	152.00	152.00	Q1	.00
03 KINGSPORT HEMATOL	NCE	093008	093008	129.00	129.00	Q1	.00
			PAGE TOTALS	47,038.00	47,038.00		.00
			CLAIM TOTALS				

* MESSAGES

Q1 DUPLICATE SERVICE.
XO THE CHARGES FOR THIS SERVICE ARE NOT COVERED UNDER THE TERMS OF YOUR POLICY.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

RXP PRESCRIPTION DRUGS
DOC PHYSICIAN VISIT
NCE NON-COVERED EXPENSES
CHM CHEMOTHERAPY

FORM G-27-C-9410 RETAIN THIS FORM FOR YOUR RECORDS CA002

Western-Southern Life
400 BROADWAY · CINCINNATI, OHIO · 45202

EXPLANATION OF CANCER CLAIM

0821

POLICY NO	CLAIM ID NO	CLAIMANT	DATE	PAGE
008918767	090330031-00	GRANVILLE D MARSHALL	02/02/09	01 OF 01

SEND TO:

GRANVILLE D MARSHALL
230 FEDDERSON ST
KINGSPORT TN 37660-1949

BENEFITS PAID TO DATE:
$ 31,984.86

FIRST SERVICE DATE:
08-28-03

PLAN CODE:
4363

PROVIDER/DRUG NAME	SERV TYPE	DATES OF SERVICE FROM	DATES OF SERVICE TO	TOTAL CHARGES	INELIGIBLE CHARGES	* MSG	BENEFITS PAYABLE
00 GASTROENTEROLOGY	SUR	060408	060408	438.06	321.06	Y1	117.00
00 GASTROENTEROLOGY	SUR	061108	061108	773.01	589.01	Y1	184.00
			PAGE TOTALS	1,211.07	910.07		301.00
			CLAIM TOTALS	1,211.07	910.07		301.00

*MESSAGES

Y1 THE CHARGES EXCEED THE AMOUNT ALLOWED BY YOUR POLICY.
.. A CHECK FOR $ 301.00 WAS ISSUED TO GRANVILLE D MARSHALL

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

SUR SURGEON

FORM G-27-C-9410 RETAIN THIS FORM FOR YOUR RECORDS CA001